ICF/MR FACILITY TRANSFER

(To be used for ICF/MR facility residents transferring from ICF/MR to Medicaid Waiver Funded Services)
Mail to: TennCare Division of Long Term Care, 729 Church St., Attention: PAE Unit, Nashville, TN 37247

A. This section to be completed by TennCare Date: _____

Reviewed by: _____

Control Number: _____

Transfer Criteria Met: _____

☐ YES Approved from _____ through _____

☐ NO Please resubmit PAE form in its entirety

Reason:

B. RECIPIENT INFORMATION

Name: _____ Sex: ____ DOB: _____
Last First Middle

Social Security Number: _____ Medicaid Number: _____

C. PAYMENT SOURCE UPON TRANSFER

☒ Medicaid Waiver

☐ Other

D. DESIGNATED CORRESPONDENT

Name: _____
Last First Middle

Address: _____

City, State, Zip: _____ Phone Number: ( )

E. TRANSFERRING FACILITY: _____ Provider Number: _____

Address: _____

City, State, Zip: _____

Contact Person: _____

Phone Number _____

Admit Date: _____ Projected Move Date: _____

Current Level of Care: ICF/MR

F. ADMITTING FACILITY: _____ Provider Number: _____

Address: _____

City, State, Zip: _____

Contact Person: _____ Phone Number: ( )

Transfer Request Date _____

Current Level of Care: HCBS

G. Plan of Care (HCBS waiver-covered services):

____

Physician's Signature _____

Version 8/28/00